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in Spain: a  
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# VIEWS & REVIEWS

## Doctors are key to welfare reform

PERSONAL VIEW **Clare Bamba**

**T**he UK government's comprehensive spending review has set out plans for unprecedented cuts to public sector funding. A particular focus has been on the Department for Work and Pensions' budget and the £192bn (€215bn; \$300bn) paid each year in welfare benefits.

Most attention has focused on incapacity related benefits (Incapacity Benefit, Disability Living Allowance, and Employment and Support Allowance), which account for £12.5bn of the welfare bill. The coalition government intends to move all the current 2.6 million recipients of incapacity related benefits onto other benefits (such as Jobseeker's Allowance or Employment and Support Allowance). This will be done by using private sector agencies to reassess the health and fitness of all recipients over the next four years.

Those deemed "fit for work" will be transferred immediately to the lower paying Jobseeker's Allowance (box). Those deemed to be too "incapacitated" for work will be placed on the Employment and Support Allowance, with a "support" premium and no conditions. Those considered "sick but able to work" will be placed on Employment and Support Allowance with a "work related activity" premium. Failure to engage in compulsory "work related activity" would result in loss of this premium and placement on the basic rate of the Employment and Support Allowance.

### Weekly benefit rates in 2010

UK poverty line: £115

Incapacity Benefit: £91.40

Employment and Support Allowance (with support premium): £96.85

Employment and Support Allowance (with work related activity premium): £91.40

Employment and Support Allowance (basic): £65.45

Jobseeker's Allowance: £65.45

Income Support: £65.45

Sources: Department for Work and Pensions; The Poverty Site ([www.poverty.org.uk](http://www.poverty.org.uk))

The reforms also mean that those deemed "sick but able to work" will see their entitlement to Employment and Support Allowance limited to one year. After a year they will have no right to benefits (not even Jobseeker's Allowance) and will therefore have to rely on family support, charities, or means tested assistance (Income Support). Of the 1.5 million claimants of Incapacity Benefit currently being reassessed, it is expected that more than half will be placed into this group.

These reforms have considerable implications for patients who receive Incapacity Benefit and potentially for their relations with general practitioners and other healthcare providers. The increase in surveillance, the uncertainty about benefit entitlement, and the stigma attached to being marked out by politicians and the press as "welfare scroungers" may well have negative effects on recipients' self esteem and mental wellbeing. The reduced income they will receive is also likely to have a detrimental effect on their health and wellbeing. And recipients of Incapacity Benefit may be less willing to see their general practitioners and other health professionals because they may begin to perceive them as instruments of this renewed state surveillance.

Patients who claim incapacity related benefits often have complex and multiple chronic health conditions, and they have been out of the labour market and dependent on low value state benefits for a long time. They did not benefit from the economic boom, but the coalition government seems determined that they will bear the brunt of the bust.

Such welfare reforms may cut central government costs, but they are highly unlikely to be health promoting. In addition, the welfare reforms are clearly not based on evidence of "what works" but on an ideological desire to shrink the state, combined with the view that those receiving Incapacity Benefit are work shy rather than chronically ill.

General practitioners and other primary

**Patients who claim Incapacity Benefit often have complex and multiple chronic health conditions ... the coalition government seems determined that they will bear the brunt of the bust**

healthcare providers therefore hold the key to reducing receipt of Incapacity Benefit by tackling the root cause: ill health. If welfare reform is actually about getting people into work (rather than just cutting expenditure, shrinking the state, and stigmatising the poor) then improving health is the most important first step in this process.

However, in all of the coalition's talk of welfare reform, there has been very little mention of illness or of the potential role of health professionals in the process of return to work. In contrast, the research evidence indicates that a "health first" approach to welfare reform is the most effective. In 2009 the National Institute for Health and Clinical Excellence released evidence based guidance on managing long term sickness absence and incapacity for work (*BMJ* 2009;338:b1259). It recommended that integrated programmes, combining traditional vocational training approaches, financial support, and health support on an ongoing case management basis, should be commissioned to help Incapacity Benefit recipients enter or return to work. The institute considers these integrated approaches to be the most effective way to enhance the employability of people in long term receipt of Incapacity Benefit.

Abandoning millions of people in deprived communities to a life on benefits is not desirable; but for welfare reform to be effective it needs to be considered outside the ideological box of spending cuts and to be based actively on the available research evidence.

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# Why we shouldn't put the clocks back this weekend

PERSONAL VIEW Mayer Hillman

Lack of exercise is a major public health problem in the United Kingdom, contributing to the incidence of chronic illness. Adults are recommended to engage in at least 30 minutes of moderate or vigorous activity daily and children at least an hour. However, surveys have shown a trend towards declining fitness, on the basis of which it has been predicted that more than half the population will be clinically obese by 2050.

Health experts have proposed urgent action to remedy this situation, and the government now aims to get far more of the inactive population walking or gardening regularly or, preferably, taking up more vigorous physical activity, such as sports, aerobics, or cycling (especially as a means of travel). Although most people are aware of the benefits—a lessened risk of coronary heart disease, obesity, diabetes, hypertension, and some cancers—routine physical activity features in few people's everyday lives. Only a small proportion of adults are motivated to undertake it throughout the year, and the school curriculum allocates insufficient time for it. In addition to removing the social, economic, and psychological barriers to activity, the measure seen to be most effective is providing more public facilities and open spaces—and networks of safe walking and cycling routes to reach them—that are sufficiently local that the journeys to get to them are not so long that the actual activity is curtailed.

Research has shown that people are happier, more energetic, and less likely to be sick in the longer and brighter days of summer, whereas their mood tends to decline—and anxious and depressive states to intensify—during the shorter and duller days of winter. People have a greater sense of wellbeing in daylight and overwhelmingly prefer it to artificial

light. The common reaction to the prospect of less daylight and sunlight when the clocks are put back at the end of October, signalling as it does the end of outdoor activity and the onset of a largely indoor leisure life, is a negative one.

The source of the problem is that on average over the year only one or two of our waking hours in the mornings are spent in darkness, whereas nearly half of the 10–11 waking hours after midday are in darkness. The critical limiting factor is obviously the onset of dusk.

In 1988 the Policy Studies Institute published a study on the consequences of the UK keeping British Summer Time during winter (by not putting the clocks back in October in one year) but still putting clocks forward in the subsequent spring, thus putting the UK one hour ahead of Greenwich Mean Time in the winter and two

hours ahead in summer (known as “Single/Double Summer Time”).<sup>1</sup>

This study and a just published study of the specific effects of such a move on Scottish life point to a wide range of advantages.<sup>2</sup>

Not the least of these is the additional hour of evening daylight in every day of the year but, because we get up after sunrise for most of the year, the loss of an hour of morning daylight in winter only.

It is surprising therefore that the positive effect of increasing the number of “accessible” daylight hours in this way in terms of promoting physical health and wellbeing has been consistently overlooked. As most children are restricted from going out after dark, the lighter evenings would enable parents to let them spend more time outdoors. A significant majority of older people impose a curfew on themselves, preventing them from going out after dark,

owing to anxiety about assault, and poorer vision and hearing.

The extra hour of evening daylight would lessen these concerns and enable far wider take-up of outdoor leisure and social activities. The additional hours of daylight would considerably increase opportunities for outdoor leisure activities: about 300 more for adults and 200 more for children each year, given typical daily patterns of activity.

There is strong support for such a clock change among all road safety organisations; many sectors of industry, especially tourism and leisure services; nearly all bodies involved in sport, recreational, and cultural activities and those engaged in overseas trade, travel, and communications; and groups representing children, teenagers, women, pensioners, and people living in rural communities. Any government introducing this reform is therefore likely to reap substantial political rewards, as public opinion in the UK has repeatedly been shown to favour the change. The ratio of those in favour to those against is now about 4:1 in England and Wales, while in Scotland opinion is fairly evenly divided despite being coloured by the unbalanced portrayal of the effects of a change in sections of the Scottish media.

Adopting this proposal for a clock change is an effective, practical, and remarkably easily managed way to better align our waking hours with the available daylight during the year. It must be rare to find a means of vastly improving the health and wellbeing of nearly everyone in the population; here we have it, and it only requires a majority of MPs walking through the “ayes” lobby in the House of Commons.

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References are in the version on bmj.com

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ROB WHITE

**The additional hours of daylight would considerably increase opportunities for outdoor leisure activities: about 300 more for adults and 200 more for children each year, given typical daily patterns of activity**

# Table talk

There is a literary genre known as table talk—that is to say, the private conversations or monologues of an important figure, taken down and printed in book form. The most famous examples, perhaps, are the table talk of Hitler and Coleridge.

The neurologist Walter Russell Brain, later Sir Russell and then Lord Brain, contributed to this genre with a short book, *Tea with Walter de la Mare*. It starts with the strangely touching statement that “my friendship with Walter de la Mare

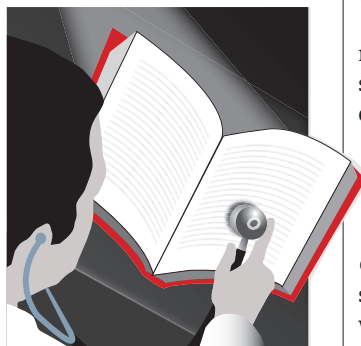
began in 1942, nine years before I met him.” But from 1951 until a few hours before the poet’s death in 1956 Brain often took tea with him and found his conversation so magical that he wrote a record of it immediately after their meetings.

Walter de la Mare (1873–1956) was among the most famous poets of his day, but he is not much read now, I suspect perhaps because there is a “neither fish nor fowl” quality to his verse, which seems to oscillate uneasily between modernism and traditionalism. Brain himself was a poet, as was the neurologist before him Henry Head and the great neurophysiologist Charles Sherrington. Brain, who thought that Sherrington’s verse was pleasant but undistinguished, tells the story of how Sherrington, who was very modest about his poetry, published it under the name of C S Sherrington, whereupon a reviewer praised “Miss Sherrington’s” work. Compared with insult, how delightful is malice so decorously expressed!

There are other little vignettes in the book, such as the story of a performance of *The Importance of Being Earnest* in Colney Hatch Lunatic Asylum, at whose jokes the audience roared with laughter as one of its members slipped out and committed suicide. In a conversation about modes of address, Brain tells de la Mare that Home

## BETWEEN THE LINES

Theodore Dalrymple



**In those days, perhaps, doctors were uneasy about revealing differential diagnoses, even of people who were not their patients**

Office officials used to sign their letters to men awaiting execution, “Your obedient servant.”

The book has one rather curious episode. Brain says that de la Mare fell one day (he was then 81 years old) and banged his head. Thereafter he experienced dysphasia and dysgraphia, which gradually resolved, and had difficulty moving (in fact he scarcely moved from his room again). But nowhere does Brain suggest that he had had a stroke, only referring to his “brain

injury.” In those days, perhaps, doctors were uneasy about revealing differential diagnoses, even of people who were not their patients.

Indeed there hangs over the whole book, including its title, of course, an almost chintzy gentility that has now disappeared almost entirely but for which I have a nostalgia that I know is not shared by everyone. What I find rather surprising, however, is Brain’s tolerance for de la Mare’s vague supernaturalism—that is to say, his belief in, or rather flirting with, spirits and ghosts and presences and telepathy, without any apparent interest in whether they actually existed or not.

In the end Brain’s tolerance was all to the good. He describes his visit to de la Mare on the last day of his life, when the poet felt himself surrounded by “presences.”

“He had become very ill during the night . . . It was clear that he was dying, and I am sure he knew it. He greeted me with a joke about his lack of party manners. Then, after a pause, he said: ‘All these onlookers! There are so many of them, I wonder where they come from.’ He died a few hours later.”

Sometimes there are things more important than philosophical truth.

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## MEDICAL CLASSICS

All About My Mother

Directed by Pedro Almodóvar

A film in Spanish, released 1999

Spain has the world’s highest rate of organ donation from the dead, with a system in which the family must give consent, a central theme of Pedro Almodóvar’s film *All About My Mother*. Manuela’s life is turned upside down when she helplessly watches her only son, Esteban, mowed down and killed by a car in the pouring rain. They’d been to see a performance of Tennessee Williams’s *A Streetcar Named Desire* to celebrate Esteban’s 17th birthday. After waiting at the stage door to see the actress Huma Rojo, who had played Blanche DuBois, he had chased their heroine into the street for an autograph.

Manuela, a nurse who coordinates transplants at a Madrid hospital, finds herself on the receiving end of the training that she gives doctors to persuade the relatives of dead patients to agree that their organs can be donated. Ironically, earlier that day Esteban had watched her acting in a training simulation. Manuela had played a mother whose son had died, and doctors needed her consent to transplant his organs. Esteban’s heart is successfully transplanted into a patient in Galicia, but Manuela finds that she can no longer work for the transplant organisation.

Pedro Almodóvar is Spain’s seminal director, and his vibrant films embrace popular and counter cultures. These melodramas tend to deal with primal emotions concerning identity, love, sex, religion, and death, often with gay and feminist narratives, and strong women hold central roles.



Manuela decides to travel to Barcelona, which she had fled 18 years earlier. She wants to tell Esteban’s father that she was pregnant when she left, that they’d had a son, and that he has died. She gave her son his father’s name, but the man she must find is now a woman called Lola.

In Barcelona Manuela helps, and is helped by, various women—Rosa, a pregnant, HIV positive nun; Agrado, a quick witted transsexual prostitute who wants to escape the street; and Huma, whose tour of *Streetcar* has reached Barcelona and whose lesbian lover is a heroin user. *All About My Mother*’s themes of sorority and maternity are interwoven with that of performance, with much of the film set in the theatre and repeated references to *A Streetcar Named Desire*, the 1950s film *All About Eve*, and Lorca’s *Blood Wedding*.

Light relief is provided by Agrado, especially her monologue about her cosmetic surgery. “You are more authentic the more you resemble what you’ve dreamed of being,” she says, listing the cost of her enhancements in pesetas. “Almond shaped eyes, 80 000; nose 200 000 . . . Tits? Two. I’m no monster. Seventy thousand each, but I’ve more than earned that back. Silicone in lips, forehead, cheekbones, hips, and arse . . . a pint costs about 100 000 . . . You add it up, because I stopped counting.”

Manuela eventually finds Lola, who is dying from AIDS, at the nun Rosa’s funeral. Although Lola can’t meet her son Esteban, she can meet her son by Rosa. Almodóvar dedicates *All About My Mother*, which received more awards than any other Spanish film, to “Bette Davis, Gena Rowlands, Romy Schneider. To all actresses who have played actresses. To all women who act. To all men who act and become women. To all the people who want to be mothers. To my mother.”

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See **ANALYSIS**, p 922



# The art of noise

FROM THE  
FRONTLINE  
Des Spence



I feel like complaining. BBC Radio 4 is no longer covering ridiculous health stories that fuel my indignation. But I have found a new topic that causes the red mist to descend: its reporting of the arts.

Coming from a concrete state comprehensive school, I never had the benefit of a classical education. Radio 4 is obsessed with classical music, dead Russian authors, ballet, a pile of old furniture in the Tate Modern, literature prizes for books I would never read (even with a cocked gun at my head), and plays by writers who have surnames for first names. I find the establishment's definition of the "arts" schooled, excluding, tired, pompous, and just pseudointellectual intimidation. Art is much deeper than these neoclassical facades. Humble music, cooking, friendship, drawing, rap, knitting, football, baking, and humour—these are our common creativity and craft of life. Indeed, art is the antidote to the failings and misery that make up life. And the prime purpose of science is to facilitate our appreciation of art.

So is art relevant to the science of medicine? There are the various types of "art therapy," which are obviously an advance on the poisonous cocktail of mood medication. And we could much improve the aesthetic of where we work: a new picture, a lick of paint, dumping the pharma tat (wall clocks advertising dangerous and long withdrawn drugs), and binning the piles of unread (unreadable) circulars.

Beyond this, surely medicine is fundamentally a science. Certainly this has been the usual view, with the algorithms, flow charts, and micromanagement of our clinical practice.

In truth, most medical activity has nothing to do with science, only craft. There is the bedazzling art of eliciting clinical signs and being able to see when someone is actually sick. And today's most important medical craft is seeing through health seeking behaviour. The doctor's artistic flare serves to reassure without investigation or referral, sparing patients the excess of medical intervention, appropriately ignoring the guidelines—the art of non-intervention. For the best modern medicine is defined not by what we do but by what we don't do. We need doctors of judgment, not diktat. Even in medical research we desperately need creativity to challenge the school learnt.

Medicine is just a humble arts and craft cottage industry, with a little, probably wrong, science thrown in. So some doctors now might consider donning a beret, cutting off an ear, calling themselves Maurice, sporting a silver topped cane, and starting to walk backwards. For the rest of us, freeing ourselves from the schooled, excluding, tired, pompous, and pseudoscientific clichés of medicine would be a start. What to do about Radio 4 is another matter.

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# Outing the Foley catheter

THE BIGGER PICTURE  
Mary E Black



I attended Serbia's second gay pride event on a lovely autumn Sunday on 10 October, along with 1000 other marchers, 5000 police, a zillion members of the press, and an orchestrated mob of disaffected youth in search of distraction and destruction. Walking through a masked gang of teenagers carrying large steel pins and rocks, I thought most of them looked a bit lost. I asked one which street we were on, and he was quite helpful; then he ran off to wave a stick randomly and shout at the police.

The official access points were mobbed. I talked my way through three riot police cordons, got security tagged, and headed to the park. After predictable speeches we set off on a 20 minute march, with helicopters overhead and security and photographers on all sides. We chatted, blew whistles, and chanted. The environs were eerily quiet because the police kept the traffic and rampaging imbeciles half a mile away. We ended at an arts centre, where

it was packed, smoky, and boring. When you have overcome your fears, faced violence, and are ripped with adrenaline, the absence of a wild, crazy party is a real downer.

It was a far cry from a really good pride event. There were no trannies or outrageous floats, it was understandably serious, and I had NO FUN. Rather than wait three hours for the windowless police vans to take us home, I slipped away quietly through the cordons as an invisible middle aged woman. Elsewhere it got nasty, and 150 people were injured, mostly police and the dimwits with the rocks.

Meanwhile my friend and professional mentor, a distinguished US medical professor, continues to collect prestigious awards at endless sit-down chicken dinners with teary speeches. For the next one he will be wearing a urinary catheter and is wondering wryly about etiquette. I have suggested he plonk the collecting bag on the lectern, clipping it first

to avoid backward pressure, and pause for the gasps and applause. Why hide it? Plenty of older men are catheterised, but few are open about it.

Ah, the marketing opportunities attached to a "real men wear tubes" campaign. Celebrity signed catheters, glitter plastic for the Las Vegas slot machine brigade, cougar skin bag covers for the huntin' shootin' fishin' types, carbon fibre camouflage models for the generals. Designer bags containing urea resistant exotic fish might make Fashion TV. My mentor could garner yet more awards, this time with industry support and big sponsorship cheques. His supporters could wear solidarity catheters at award dinners and "out" covertly tubed politicians.

Yup, I need some humour this week. Hopefully, Belgrade's gay pride in 2011 will be more fun.

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